Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

FOUNDATION SURGICAL HOSPITAL
5410 WEST LOOP SOUTH STE 3600
BELLAIRE TX 77401

Respondent Name
WAL MART ASSOCIATES INC

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M412-0377-01

MFDR Date Received
October 4, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "You authorized this patient for a 4 day stay under authorization number CERV2011012060748. I received an EOR stated, provider may resubmit bill, with the following, for completion of review. Correction of DRG 490 to DRG 491. The accepted DX is 344.60 which are on the claim. No need to correct the DRG it will remain as 491. Please review the enclosed operative report, which clearly documents the DRG 491."

Amount in Dispute: $48,734.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**DIAGNOSIS—NOT DOCUMENTED - 344.60** Diseases of the nervous system & other disorders of the central nervous system/ **other Paralytic Syndrome / Cauda Equina SYNDROME** without mention of neurogenic bladder….Cauda Equina COMPESSION & Cauda Equina SYNDROME are NOT EQUIVALENT. Cauda Equina Syndrome, is described as a rare disorder affecting the cauda equine, which includes cauda equine compression to a severe, paralytic extent & resultant additional symptoms. It often results in a surgical emergency. The 3/2/11 surgery was not performed on an emergency basis; complet diagnosis of SYNDROME is not documented; symptoms are sate to be present for 1 year; surgery was planned & pre-authorized 1/20/11, 6 weeks prior to DOS…..It is the carrier's position that the DRG should be corrected to 491 for this bill. "

Response Submitted by: Hoffman Kelley Attorneys at Law, 5316 Hwy 290 West STE 360, Austin TX 78735

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2011 to March 5, 2011	Inpatient Hospital Surgical Services	$48,734.43	$7,868.15

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for

inpatient services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 23, 2011
   - 16- CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. ADDITIONAL INFORMATION IS SUPPLIED USING REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE
   - W1- WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 185- VALID DRG AND/OR MEDICARE NUMBER REQUIRED FOR REVIEW. PLEASE RE-SUBMIT BILL WITH PROPER INFORMATION FOR FURTHER PROCESSING
   - 5036 – COMPLES BILL-REVIEWED BY MEDICAL COST ANALYSIS TEAM
   - 5101- PLEASE REFER TO NOTE ABOVE FOR A DETAILED EXPLANATION OF THE ADDITIONAL INFORMATION NEEDED TO PROCESS YOUR BILLING

   Explanation of benefits dated May 23, 2011
   - 19- ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME
   - 5036 – COMPLES BILL-REVIEWED BY MEDICAL COST ANALYSIS TEAM
   - 5101- PLEASE REFER TO NOTE ABOVE FOR A DETAILED EXPLANATION OF THE ADDITIONAL INFORMATION NEEDED TO PROCESS YOUR BILLING

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. Which DRG code is appropriate for the services in dispute?
4. What is the maximum allowable reimbursement for the services in dispute?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   No documentation was found to support that the facility requested separate reimbursement for implantables; for that reason the MAR is calculated according to §134.404(f)(1)(A).

3. The respondent's position statement asserts that "billed DRG conflicted with medical record documentation regarding complication / comorbidity…..DIAGNOSIS—NOT DOCUMENTED - 344.60 Diseases of the nervous system & other disorders of the central nervous system/ other Paralytic Syndrome / Cauda Equina SYNDROME without mention of neurogenic bladder….WITH THE ABSENCE OF DX 344.60, THE CORRECT ASSIGNED DRG =491…Cauda Equina Syndrome is described as a rare disorder affecting the cauda equina, which includes cauda equina compression to a severe, paralytic extent…It often results in a surgical emergency. The 3/2/11 surgery was not performed on an emergency basis…symptoms are stated to be present for 1 year;

surgery was planned & pre-authorized 1/20/11 6 weeks prior to DOS." The Respondent also provided documentation from the American Academy of Orthopaedic Surgeons which states "cauda equine syndrome…is a surgical emergency" Review of box 71 on the bill submitted by the requestor finds that the provider listed code 490 as the DRG code for the disputed services. DRG code 490 is defined as "Back and Neck Procedures Except Spinal Fusion with CC/MCC or Disc Device/ Neurostimulator. The requestor billed with diagnosis code 344.60 Cauda Equina Syndrome without mention of neurogenic bladder. Per the operative report the injured employee has a "one-year history of the acute onset of severe low back and bilateral leg pain with numbness and tingling in the posterior thighs and calves...on the myelography demonstrated large central disc herniations at L2-L3, L3-L4, and L4-L5 causing high-grade stenosis and cauda equine compression at L2-L3." Based on Medicare policy DRG audits, diagnosis code 344.60 is included in the principal diagnosis codes under DRG 490, but is excluded from DRG 491. Per the submitted documentation the Division finds that diagnosis code 344.60 is not supported. Review of the submitted documentation finds that the appropriate DRG billing code for the services in dispute is DRG code 491.

4. §134.404(f)(1)(A) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 143%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov. Documentation supports that the DRG assigned to the services in dispute is 491, and that the services were provided at Foundation Surgical Hospital. Consideration of the DRG, location of the services, and bill-specific information results in a total Medicare facility specific allowable amount of $5502.20. This amount multiplied by 143% results in a MAR of $7868.15.
5. The division concludes that the total allowable reimbursement for the services in dispute is $7868.15. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, additional reimbursement in the amount of $7,868.15 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $7,868.15.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $7,868.15 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Greg Arendt	April 24, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.